

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH Stoddard  
County Elb  
Township Elb  
or Elb  
Village Elb  
or Elb  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 839 File No. 11305  
Primary Registration District No. 6198 Registered No. 15

FULL NAME Herman Williams

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Male</u>	COLOR OF RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) <u>Married</u>	DATE OF DEATH <u>March 18</u> 191 <u>4</u> (Month) (Day) (Year)	
DATE OF BIRTH <u>Feb 16</u> 18 <u>89</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>March 4</u> , 191 <u>4</u> , to <u>March 18</u> , 191 <u>4</u> —	
AGE <u>25</u> yrs. <u>1</u> mos. <u>2</u> ds. If LESS than 1 day, ___ hrs. or ___ min.?			that I last saw him alive on <u>March 15</u> , 191 <u>4</u> ,	
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u>			and that death occurred, on the date stated above, at <u>12 noon</u>	
(b) General nature of industry, business, or establishment in which employed (or employer) _____			The CAUSE OF DEATH* was as follows: <u>Lobar Pneumonia</u>	
BIRTHPLACE (City or town, State or foreign country) <u>Illinois</u>			<u>22 A</u> <u>108</u>	
PARENTS	NAME OF FATHER <u>Walter Williams</u>		(Duration) ___ yrs. ___ mos. <u>8</u> ds.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Illinois</u>		Contributory <u>Tuberculosis</u> (SECONDARY) (Duration) ___ yrs. ___ mos. <u>38</u> ds.	
	MAIDEN NAME OF MOTHER <u>Laura M. Thompson</u>		(Signed) <u>William J. Rex</u> M. D. <u>3/18/14</u> (Address) <u>Elb Mo</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Illinois</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Walter Williams</u>			LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENCE) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.	
(ADDRESS) <u>Wasco Mo.</u>			Where was disease contracted If not at place of death? _____	
Filed <u>3/18</u> 191 <u>4</u> <u>McColdwell</u> REGISTRAR			Former or usual residence _____	
			PLACE OF BURIAL OR REMOVAL <u>Elb</u> <u>Taylor Grand</u>	
			DATE OF BURIAL <u>3/19/14</u> 191 <u>4</u>	
			UNDERTAKER <u>None</u>	
			ADDRESS _____	

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc. of ..... (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "*Asthenia*," "*Anaemia*" (merely symptomatic), "*Atrophy*," "*Collapse*," "*Coma*," "*Convulsions*," "*Debility*" ("*Congenital*," "*Senile*," etc.), "*Dropsy*," "*Exhaustion*," "*Heart failure*," "*Haemorrhage*," "*Inanition*," "*Marasmus*," "*Old age*," "*Shock*," "*Uraemia*," "*Weakness*," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*PUERPERAL septicaemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. CAUSE should be stated EXACTLY. PHYSICIANS should state PLAINLY.

PLATE OF DEATH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

County Stoddard  
Township Elk  
Village \_\_\_\_\_  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

Registration District No. 839 File No. \_\_\_\_\_  
Primary Registration District No. 610 Registered No. 15

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Norman Williams

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED M  
(Write the word)

DATE OF BIRTH \_\_\_\_\_, 191\_\_\_\_  
(Month) (Day) (Year)

AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION  
(a) Trade, profession, or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (by employer) \_\_\_\_\_

BIRTHPLACE  
(City or town, State or foreign country) \_\_\_\_\_

PARENTS  
NAME OF FATHER \_\_\_\_\_  
BIRTHPLACE OF FATHER (City or town, State or foreign country) \_\_\_\_\_  
MOTHER NAME OF MOTHER \_\_\_\_\_  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) \_\_\_\_\_

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) \_\_\_\_\_  
(ADDRESS) \_\_\_\_\_

Filed 3/18 1914 W. Caldwell  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 18, 1914  
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,  
that I last saw him \_\_\_\_\_, 191\_\_\_\_,  
and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Lobar Pneumonia  
Phthisis Pulmonalis  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory Tuberculosis  
(Secondary) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 38 ds.  
(Signed) William J. Fox M. D.  
3718 1914 (Address) Evex MA

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS):

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REINTERMENT \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_, 191\_\_\_\_

UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

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use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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